CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/18/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPL	ETED
		155348	B. WIN			02/25/2	U11
	PROVIDER OR SUPPLIER			2819 N	ADDRESS, CITY, STATE, ZIP CODE ORTH ST JOSEPH AVENUE SVILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
F0000	State Licensure Sincluded the Investinct IN00086322. Complaint IN00 Federal/State defallegations are ciff F282 and F312. Survey Dates: February 21, 22, Facility Number: Provider Number AIM Number: 10 Survey Team: Jodi Meyer, RN, Diane Hancock, Inc.	000239 r: 155348 00290150 TC RN RD [2/21-23/11]	FOO	000	Please accept this Plan of Correction as my credible allegation of compliance. I als respectfully request this Plan Correction be accepted as pa compliance of the alleged deficiencies. This Plan of Corection is submitted under Federal and State regulations statutes applicable to long ter care providers. This Plan of Correction does not constifute admission of liability on the pathe facility, and such liability is hereby specifically denied. The submission of this Plan does constitute agreement by the facility that the surveyor's find or conslusion are accurate, constitute deficiency or that the scope and severity regarding of the deficiencies cited are correctly applied.	and m ant of second ings	
					!		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4MR811

Facility ID:

000239

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155348	BER: A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/25/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2819 NORTH ST JOSEPH AVENUE EVANSVILLE, IN47720					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE	(X5) COMPLETION DATE		
	Supplemental sa These deficiencie							

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155348	B. WIN			02/25/20	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ORTH ST JOSEPH AVENUE		
	W CARE CENTER			EVANS	SVILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	F02	TAG	1. C.N.A. #2 was suspended		DATE
F0225		review and interview, the	F02	25	immediately pending		03/27/2011
SS=E	_	report and investigate			investigation. Nursing		
	•	f mistreatment of			Administration was inserviced	by	
	•	ity staff; in that, 4 of 4			the Executive Director regarding	ng	
	supplemental san	nple residents [V, W, X,			ISDH reporting regulation		
	Z] who complain	ned of mistreatment			including immediately notifying the Executive Director and tim		
	and/or roughness	by CNA #2, in the			reporting to appropriate	Ciy	
	supplemental san	nple of 9, failed to have			agencies. 2.Interviews conduc	cted	
	their allegations	fully investigated and			with interviewable residents w	ho	
	reported, resultin	g in the CNA continuing			had been cared for by cna #2		
	to work at the fac	cility and interact with			regarding care & treatment performed by any associates.	No.	
	residents.	, and the second			allegations of mistreatment	NO	
					and/or roughness were reported	ed	
	Findings include:	•			during interviews. Licensed		
	1 mamgs merade	•			Nurses were inserviced by Sta	off	
	1. On 2/22/11 at	11:00 a.m. the			Develpment coordinator on 2/22/11 regarding ISDH report	ing	
		CNA #2 was reviewed.			regulation. Cnas were inservice	-	
		nire date was 7/25/07			on 2/22/11 by SDC regarding		
		nt after maternity leave of			ISDH reporting regulation. 3.		
		ne file contained fifteen			Executive Director will receive		
	_	forms and/or one on one			verbal report daily 7 days a we from Nursing Administration or		
					any allegations of mistreatmer		
	_	nployee. Four corrective			and/or roughness of resident b		
		egards to neglect and/or			facility staff. There will be		
	*	dents, with dates ranging			continued ongoing education of		
	from October 200	•			residents, upon admission and		
	Corrective action				quarterly during Resident Cou by SSD, of new associate hire		
	*	lents complaints of			by SSD, or new associate fine by SSD, and all associates	~	
	rudeness, being r	ough and improper care."			quarterly by SDC. Any reports	s of	
					mistreatment 7/or roughness v		
	Two therapists an	nd a CNA provided			be reported immediately to the		
	written statement	tatements of the residents'			Executive Director.4. Audits w be completed by Nursing	'''	
	concerns of the events that occurred on				Administration and the Execut	_{ive}	
	4/5 or 4/6 and 4/8	8/10, as follows:			Director daily, 7 days a week f		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
THIBTEAU	or condition	155348		LDING		02/25/2		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER				ORTH ST JOSEPH AVENUE			
	EW CARE CENTER			1	SVILLE, IN47720			
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG		20	DATE	
	#1, regarding Resplease don't tell relike it if they was bottom then go be 'am not going to don't do that at he take a shower all happened.' Conv. Monday or Tueson Recorded on 4/9/Therapist Assistat X, "4/8/10 Residupset after bath, girl gave me a had colostomy'." Recorded on 4/9/regarding Reside "On Friday Aprill OTA#1] approace and told me that the upset the previous said that CNA #2 day and Resident CNA #2 was very raised her voice worth of the previous and told me upset and crying on during this day	ent W and Resident V, 19, 2010 [name of whed me in the hallway Resident W had been as day, April 8, 2010. She 2 had been her aide that at W stated to her that ay rude to her and had with her. [name of Resident W was very over the situation. Later			months to ensure all allegation of mistreatment and/or roughr of residents are investigated a reported. Audits will continue be completed 5 times a week 3 months, then 2 times a weel 6 months. Audit findings will be reviewed by the PI committee monthly, for 12 months. PI Committee will determine neefor further audits. Plans will be updated as indicated.	ness and to for k for be		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPL	LETED	
		155348	B. WING			02/25/2	011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER	S.			ORTH ST JOSEPH AVENUE			
PARKVIE	EW CARE CENTER				VILLE, IN47720			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE	
		de the previous day.						
		me ' I didn't know						
		so mean. She done a lot						
	of yelling and wa	as mean yesterday.' I told						
	my nurse, LPN #	to of the two incidents						
	and she had me v	write this statement and						
	said she would ta	ake care of it."						
	LPN #5 recorded	l on 4/9/10, "After a RCT						
		to me 2 of her residents						
		aining of] [name of]						
		nean to me' I spoke with						
		sident V stated that						
		2 was hateful to her and						
		dn't want to be bothered						
		questioned as to what						
		•						
		2 said, Resident V stated						
		ne said but how she said						
	it.'							
	-	Resident W, she stated						
		#2 had an 'attitude' with						
		ful and this made her feel						
	bad. She then sta	ted 'she was so short with						
	me.' She c/o [na	me of] CNA #2 to						
	therapy. I then s	poke with Resident X						
	who had c/o [nar	ne of] CNA #2 to						
	therapist. Reside	ent stated she didn't like						
	-	s her a bath because she						
		een her legs good and she						
	_	ce with same cloth she						
		area with. She also states						
	•	NA#2 is very short with						
	her."	147 tm 2 15 very short with						
	1101.							
			1			1	I	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155348			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 02/25/2011	
	PROVIDER OR SUPPLIER		B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2819 NORTH ST JOSEPH AVENUE EVANSVILLE, IN47720				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	on the back, "In a corrective action performance, you corrective action limited to; Termi signed by the CN The allegations we State agency, or include other result The corrective action and a reviewed and/or Administrator. During an interval Administrator, or she was unaware was missed and a regarding resider At that time, a gramissing item log Administrator. The indicated Resides being "manhandle" and that she we care on 12/16/10 same CNA as in The grievance in following:	iew with the n 2/23/11 at 10:15 a.m., of how the allegation not been reported					

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		100348	B. WIN			02/25/2	UII
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
	EW CARE CENTER			EVANS	ORTH ST JOSEPH AVENUE VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		t on 12/16/10, regarding		IAG			DATE
		me of housekeeping					
		walking down Dogwood					
	_	. [name of] Resident Z					
		de her room in the					
		of] Resident Z asked me					
		g today. I told [name of]					
	l ,	[name of two CNAs]					
		Lesident Z said, 'I am sore					
		g me up this morning.' I					
	asked Resident Z	Z who got her up.					
	Resident Z said,	' I don't know who she					
	was but she man	handled me and now I am					
	sore.' I asked he	r if she knew what time					
	she got up and sh	ne said it was early.					
	Resident Z was r	rubbing her hip and lower					
	stomach area. I	went and reported this to					
	my supervisor an	nd we reported to [name					
	of] Administrate	or."					
		ten by RN #2 in the					
	~	gation, on 12/16/10,					
	**	ped time line/statement					
	the following:						
		ved report that resident					
		n interview due to some					
	concerns that had						
		dent in activity at this					
		me briefly. Resident was					
		upset this AM by					
	_	dent stated that she was					
	_	e was rushing with her					
	this AM. I asked	l resident to speak with					

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000239

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155348	(X2) MULTIPLE CO A. BUILDING B. WING	COMP	(X3) DATE SURVEY COMPLETED 02/25/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2819 NORTH ST JOSEPH AVENUE EVANSVILLE, IN47720					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) vity was finished.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE	(X5) COMPLETION DATE		
	10:30 a.m Resistated that she not I asked resident that happened this Alproceeded to tell mean to her, but around when the for the day- 'I fel man-handling mashe was not mad in trouble. She s slow down & tel Resident then stated that she was ged day. Resident she someone had sat stated that she again trouble about they were just rus snow outside. 10:45 a.mSkin complaints of particular to hall to gestated she didn't YES I washed here.	dent came to my office & eeded to talk to me now. To tell me about what had M that upset her. She me that nobody was they were just rushing y got her dressed & up to like they were just et.' Resident stated that & did not want anybody stated to just 'ask them to lone what is going on.' In the lap this morning setting her ready for the nowed this nurse how across her lap. Resident gain did not want anyone thisshe stated maybe shing because of the lassessment done No						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155348			(X2) MULTIPLE CO A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/25/2011
NAME OF I	PROVIDER OR SUPPLIEF	t .		ADDRESS, CITY, STATE, ZIP CODE ORTH ST JOSEPH AVENUE	
PARKVIE	EW CARE CENTER			SVILLE, IN47720	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	five areas of wor CNA #2 in regar Z allegations. None of Residen reported to State investigated thor The above intera improvements for of CNA #2 's emhistory.	oughly. ctions and/or work or CNA #2 were not part ployee record or work relates to complaint			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155348		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 02/25/2011		
			B. WIN			J , ,	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	EW CARE CENTER			I	ORTH ST JOSEPH AVENUE SVILLE, IN47720		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
F0226	Based on record	review and interview, the	F02	26	1.Nursing Administration was		03/27/2011
SS=E	facility failed to f	follow their policy for			inserviced by the Executive Director regarding ISDH report	tina	
-	investigation and	reporting allegations of			regulation including immediate		
	abuse, for 2 of 2	allegations of			notifying the Executive Directo		
	mistreatment and				and timely reporting to		
		eged to have occurred			appropriate agencies.2. Facilit		
		#2). This affected 4 of 4			Policy/Procedure was revised	and	
	`	· /			updated on 3/7/11 to meet		
		nple residents [V, W, X,			regulatory intent. Nursing Adm and Licensed Nurses inservice		
		ed of mistreatment			on 3/8/11 regarding following	eu	
	_	by CNA #2, in the			policy of the facility.3. The		
	supplemental san	nple of 9.			Executive Director will receive		
					verbal report 7 days a week fro	om	
	Findings include:	· ·			Nursing Admin on any allegati		
					of mistreatment and/or roughn		
	1. The Administ	rator provided the			of residents by the facility staff		
		ect Policy" on 2/21/11 at			There will be continued ongoir education of residents upon	ig	
	-	0 indicated. "The revised			admission and quarterly during	נ	
	reporting protoco				Resident Council by SSD, of n		
		Parkview Care Center			associate hires by SSD, and a	II	
	_				associates quarterly the the		
		lowed." "The facility			SDC.4. Audits will be		
		all alleged violations			completed by Nursing Admin.	and	
	-	atment, neglect, or abuse,			the Executive Director daily, 7 days a week, for 3 months to		
		s of unknown source and			ensure all allegations of		
	misappropriation	of resident property are			mistreatment and/roughness of	of	
	reported immedia	ately to the administrator			residents are investigated and		
	of the facility and	d to other officials in			reported. audits will continue		
	accordance with	State law through			be completed 5 times a week to		
	established proce	· ·			3 months, then 2 times a week 6 months. audit findings will b		
	p. 000				reviewed by the PO Committee		
	The noticy was n	ot followed regarding			monthly, for 12 months. Pl	-	
		investigating for the			Committee will determine need	b b	
					for further audits. Plans will be	•	
	following allegat	ions:			updated as indicated.		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING		COMPL		
		155348	B. WIN			02/25/2	011	
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	KOVIDEK OK SUITEIEN			1	ORTH ST JOSEPH AVENUE			
PARKVIE	EW CARE CENTER			EVANS	VILLE, IN47720			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		:00 a.m., the employee						
		vas reviewed. The						
	1 * *	date was 7/25/07 with						
		er maternity leave of						
	1 -	ne file contained fifteen						
		forms and/or one on one						
	· -	nployee. Four corrective						
		egards to neglect and/or						
	poor care of resid	dents, with dates ranging						
	from October 20	08 to April 2010.						
	Corrective action	n, dated 4/14/10,						
	indicated, "Resid	lents complaints of						
	rudeness, being r	ough and improper care."						
		nd a CNA provided						
	written statemen	ts of the residents'						
	concerns of the e	events that occurred on						
	4/5 or 4/6 and 4/5	8/10, as follows:						
	D 1.1 4/0	/10.1 PI : 1.EI : .						
		/10 by Physical Therapist						
	-	sident X, "[name of PT]						
	_	no body but would you						
	1	sh your face then go to						
		back up to your face?I						
		name no one but I just						
		ome, but you know, I						
		the time before this						
	happened.' Conv	versation happened on						
	Monday or Tues	day 4/5 or 4/6/10."						
		40.1						
		/10, by Occupational						
	_	ant #1, regarding Resident						
	X, "4/8/10 Resid	ent found tearful and						

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Event ID:

4MR811 Facility ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAIN	OF CORRECTION	155348	A. BUILDING		02/25/2011	
		100010	B. WING	ADDRESS, CITY, STATE, ZIP CODE	02/20/2011	
NAME OF F	PROVIDER OR SUPPLIER			ORTH ST JOSEPH AVENUE		
	EW CARE CENTER		EVANS	SVILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION DATE	
1110		with patient stating, 'that			Bille	
	•	ard time about my				
	colostomy.'"	ara viiii a ac cav iii j				
	Recorded on 4/9/	/10, by CNA #6				
	regarding Reside	ent W and Resident V,				
	"On Friday April	19, 2010 [name of				
	OTA#1] approac	hed me in the hallway				
	and told me that	Resident W had been				
		s day, April 8, 2010. She				
	said that CNA #2	2 had been her aide that				
	-	t W stated to her that				
		y rude to her and had				
		with her. [name of				
	-	Resident W was very				
		over the situation. Later				
	on during this da	• • •				
		old me that she also had				
		de the previous day.				
		me 'I didn't know CNA#2				
		n. She done a lot of				
		mean yesterday.' I told				
		5 of the two incidents				
	and she had me v	write this statement and				
	said sne would ta	ike care of it.				
	LPN #5 recorded	l on 4/9/10, "After a RCT				
		to me 2 of her residents				
		ained of] [name of] CNA				
	- 1	o me' I spoke with the				
	-	ent V stated that [name				
		hateful to her and acted				
	=	ant to be bothered with				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
		155348	B. WING		02/25/2011
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
DΔRK\/IE	EW CARE CENTER		I	ORTH ST JOSEPH AVENUE SVILLE, IN47720	
				• • • • • • • • • • • • • • • • • • •	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
		tioned as to what [name			
	•	Resident V stated 'it			
	-	said but how she said it.'			
		Resident W, she stated			
	-	#2 had an 'attitude' with			
	her and was hateful and this made her feel				
		ted 'she was so short with			
		me of] CNA #2 to			
	-	poke with Resident X			
		ne of CNA #2 to			
	-	ent stated she didn't like			
	-	s her a bath because she			
		een her legs good and she			
	will wash her fac	ce with same cloth she			
	washed her peri	area with. She also states			
	that [name of] C	NA#2 is very short with			
	her."				
	The corrective A	ction form was recorded			
	on the back, "In	the event of further			
	corrective action	in this or another area of			
	performance, you	u will be subject to the			
	corrective action	below, including but not			
	limited to; Termi	ination." The form was			
	signed by the CN	VA #2 and LPN # 1.			
	The allegations v	vere not reported to the			
		fully investigated to			
		ident or staff interviews.			
	The corrective ac	ction form was not			
	reviewed and/or	signed by the			
	Administrator.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155348			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/25/2011	
	PROVIDER OR SUPPLIER		2819 N	ADDRESS, CITY, STATE, ZIP CODE ORTH ST JOSEPH AVENU SVILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	she was unaware was missed and regarding resider At that time, a grain missing item log Administrator. Traindicated Reside being "manhand #2 and that she was care, on 12/16/10 the same CNA a The grievance in following: Housekeeping A written statemen Resident Z, "[natassistant #1] was hall at 10:00 a.m was sitting outside hallway. [name who was workin Resident Z I saw down the hall. If from them getting asked Resident Z Resident Z said, was but she man sore.' I asked he	n 2/23/11 at 10:15 a.m., of how the allegation not been reported				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155348			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/25/2011	
	PROVIDER OR SUPPLIER		2819 N	ADDRESS, CITY, STATE, ZIP CODE ORTH ST JOSEPH AVENU! SVILLE, IN47720	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	stomach area. I	went and reported this to nd we reported to [name or."				
	grievance investion indicated in a type the following: "9:50 a.mReceivas in need of an concerns that had 10:05 a.m Resistime spoke with asked if she was something. Resisted that she may after her activation of the same activation of the	ten by RN #2 in the gation, on 12/16/10, bed time line/statement ved report that resident in interview due to some dibeen voiced. dent in activity at this me briefly. Resident was upset this AM by dent stated that she was e was rushing with her diresident to speak with vity was finished. dent came to my office & beded to talk to me now. To tell me about what had M that upset her. She me that nobody was they were just rushing by got her dressed & up to the like they were just et. Resident stated that & did not want anybody tated to just 'ask them to a lime what is going on.' Interest the like they morning the lap this morning				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLAN	OF CORRECTION	155348	A. BUILDING		02/25/2011
		1000.0	B. WING	ADDRESS, CITY, STATE, ZIP CODE	32/20/20 * 1
NAME OF I	PROVIDER OR SUPPLIER	1		ORTH ST JOSEPH AVENUE	
	EW CARE CENTER		EVANS	SVILLE, IN47720	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI	ATE COMPLETION DATE
1110		etting her ready for the	1110		2.112
	·	nowed this nurse how			
	someone had sat across her lap. Resident				
		gain did not want anyone			
	· ·	thisshe stated maybe			
	they were just rushing because of the				
	snow outside.				
	10:45 a.m Skin	assessment done No			
	complaints of pa	in"			
	CNA #2's writter	n statement for this			
	incident was as f	follows: "I and an oriente			
		room got clothes pan out			
		et supplies. Resident			
		want to be washed. I said			
		er up got her transferred			
	_	air] stripped bed left			
	room."				
	RN #2, at 3:00 n	.m. on 12/16/10, recorded			
		k improvement with			
		ds to the above Resident			
	Z allegations.				
	_				
		t Z's allegations had been			
	reported to State				
	investigated thor	0 1			
		ctions and/or work			
	_	or CNA #2 were not part			
	l '	ployee record or work			
	history.				
		1			
	I his federal tag i	relates to complaint			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
111,1211111	or conditions	155348	A. BUILDING		02/25/2011	
			B. WING	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			ORTH ST JOSEPH AVENUE		
	W CARE CENTER		EVANS	SVILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE	
1110	number IN00086		1110		5.112	
	number invoced					
	3.1-28(a)					
	3.1-20(a)					

000239

	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155348				ETED	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ORTH ST JOSEPH AVENUE		
PARKVIE	EW CARE CENTER				SVILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0241 SS=E	record review, the residents received response from state call light for assist interviewable in present who attent (Residents J, R, State resident (Y) who light response. Findings include 1. The group into 2/22/11 at 3:00 pt (19) residents proposed alert and oriented the Resident Rost Director of Nursea. The state of the Resident Formal and to wait for call (Residents J, R, State of the Residents J, R, State of the	etion, interview and e facility failed to ensure d prompt and appropriate aff when summoned by stance. This affected 5 of residents within the 19 inded the group interview S, T, U) and 1 of 1 was observed for call : erview was held on i.m. Eight (8) of nineteen resent were identified as d and interviewable, on iter, provided by the residents indicated they fall lights to be answered S, T, U). One resident d as interviewable, ident had waited 1 and answer to the call light on residents, identified as dicated they waited 30 for call lights to be 10:55 a.m., Resident Y's reserved to be on, for an of time. The light	F02	41	1. All associates were inservi on prompt and appropriate response when summoned by call light for assistance.2. Licensed Nurses were inserviced on 3/8/11 regarding Policy/Procedure for use of the call light. Other facility staff we inserviced on 3/9/11 regarding Policy/Procedure for use of the call light. 3. Call light tracking trending completed on each up the assigned cna on 3/10/10 Care guides updated to better anticipate residents needs base on tracking & trending results.4.Call light tracking & trending and interviewable resident interviews for responsitime will be conducted 3 times week for 3 months, then 2 times week for 3 months, then 1 time per week for 6 months by Nursing Admin. Audit findings be reviewed by the PI Committee monthly for 12 months. PI committee will determine need for further audits.	the ced eere g & nit 1. sed	03/27/2011

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		155348	B. WING		02/25/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
DΔRK\/IF	EW CARE CENTER		I	ORTH ST JOSEPH AVENUE SVILLE, IN47720	
				· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE DATE
		PNs #2 and #3 were			
		the resident's room, and			
		e nurses' station, at			
		, with the audible call			
		nd the light outside the			
	resident's room o	_			
	At 11:00 a.m L	PN #3 entered the room.			
	-	ated she wanted to get up			
		LPN turned off the call			
	light, indicated sl	he would tell "the girls,"			
	and exited the room. No one returned to				
	the room until 11:25 a.m.				
	At 11:25 a.m., C	NA #2 delivered the			
	lunch tray to the	resident's room. The			
	resident indicated	d she had wanted to get			
	up in the chair be	efore lunch. The CNA			
	indicated the resi	dent was going to get a			
	shower after lunc	ch. A guest of the			
	resident stated, "	Can she not get up in the			
	chair for lunch?"	The CNA then assisted			
	the resident to a l	bedside chair for her			
	meal.				
		ster, provided by the			
		es on 2/21/11 at 11:30			
		esident Y had a history			
	of falls, incontine	-			
		ly Living, and problems			
	with pain.				
	On 2/24/11 at 2:0	00 p.m., the observation			

000239

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155348			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/25/2011	
	PROVIDER OR SUPPLIER		STREET 2 2819 N	ADDRESS, CITY, STATE, ZIP CODE ORTH ST JOSEPH AVENUE VILLE, IN47720	_	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	LPN #1 and the and indicated Reside #2's assignment to was late, including 3. The Policy and of Call Light [not the Director of National Procedural Steps limited to, the formal steps limited to, the formal steps lights at all the "Answer all call or not you are as "Answer all call courteous manners soon as you enter "Never make the busy to give assistance before	onnel must be aware of imes." lights promptly whether signed to the resident." lights in a prompt, calm, or; turn off the call light as a the room." resident feel you are too stance; offer further you leave the room."				

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155348 A. BUILDING B. WING (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR COMPLETE 02/25/2011				ETED			
	PROVIDER OR SUPPLIER			2819 N	ADDRESS, CITY, STATE, ZIP CODE ORTH ST JOSEPH AVENUE SVILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
F0282 SS=D	interview, the face each resident with written plan of car residents, in that his own in his root indicated he need G) Finding includes During the initial a.m., RN #2 indicated a restorative program with assistance, to room for meals, further interview mobility alarms, when he wanted Resident G's clin on 2/21/11 at 2:0 most recent quart Assessment, date resident required one for transfers resident had a car 1/13/11, indicating The care plan incompassisted to ambuldining room daily with a gait belt are	tour, on 2/21/11 at 9:45 cated Resident G was on gram and was walked, o and from the dining She indicated, upon, he did not have any but used the call light to go anywhere. ical record was reviewed 0 p.m. The resident's terly Minimum Data Set ed 1/13/11, indicated the extensive assistance of and ambulation. The	F02	82	1. Rehab assessed resident G safety with independent ambulating in his room. Care Plan & Care Guide updated.2. Care Plans/Care Guides were audited for activity level accura Updated as necessary. 3. Ca Guides will be reviewed weekl and updated as necessary by Nuring Administration to maint accuracy of activity level.4. Audits of Care Guides will be completed 3 times a week by assigned Department Heads fromonths, then 2 times a week fromonths. Audits will be reviewed by the PI Committee monthly, 12 months. PI committee will determine need for further audits. Plans will be updated a indicated.	All acy. re y ain or 3 or 3 r 6 ed for	03/27/2011

NAME OF PROVIDER OR SUPPLIER PARKVIEW CARE CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG The Daily Care Guide, the assignment sheet used by CNAs to guide care, was provided by RN #2 on 2/21/11 at 11:00 a.m. The Care Guide indicated Resident G "Requires assistance of one with all transfers, walking and bathing and dressing needs." Resident G was observed to be up in his bathroom, with his walker, by himself, on	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE COMPL	ETED			
PARKVIEW CARE CENTER (X4) ID PROVIDER OR SUPPLIER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The facility's falling star program. The Daily Care Guide, the assignment sheet used by CNAs to guide care, was provided by RN #2 on 2/21/11 at 11:00 a.m. The Care Guide indicated Resident G "Requires assistance of one with all transfers, walking and bathing and dressing needs." Resident G was observed to be up in his			155348	B. WIN			02/25/2	011
PARKVIEW CARE CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The Daily Care Guide, the assignment sheet used by CNAs to guide care, was provided by RN #2 on 2/21/11 at 11:00 a.m. The Care Guide indicated Resident G "Requires assistance of one with all transfers, walking and dressing needs." Resident G was observed to be up in his	NAME OF I	PROVIDER OR SUPPLIER			1			
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The facility's falling star program. The Daily Care Guide, the assignment sheet used by CNAs to guide care, was provided by RN #2 on 2/21/11 at 11:00 a.m. The Care Guide indicated Resident G "Requires assistance of one with all transfers, walking and bathing and dressing needs." Resident G was observed to be up in his	PARKVII	EW CARE CENTER			1			
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The Daily Care Guide, the assignment sheet used by CNAs to guide care, was provided by RN #2 on 2/21/11 at 11:00 a.m. The Care Guide indicated Resident G "Requires assistance of one with all transfers, walking and bathing and dressing needs." Resident G was observed to be up in his	TAG				TAG	DEFICIENCY)		DATE
sheet used by CNAs to guide care, was provided by RN #2 on 2/21/11 at 11:00 a.m. The Care Guide indicated Resident G "Requires assistance of one with all transfers, walking and bathing and dressing needs." Resident G was observed to be up in his		the facility's falli	ng star program.					
2/22/11 at 9:15 a.m. He indicated he had walked in there to use the restroom. He was observed, again on 2/23/11 at 9:10 a.m., with his walker, standing in the bathroom adjusting his clothing. No one was in the bathroom with him, or in the room. RN #2 indicated, during interview on 2/25/11 at 10:30 a.m., Resident G was being reviewed again to see if he was safe to be up on his own in his room. She indicated the resident had needed assistance to get up from his chair the evening before. This federal tag relates to complaint number IN00086322 3.1-35(g)(2)		The Daily Care C sheet used by CN provided by RN a.m. The Care G G "Requires assistransfers, walking dressing needs." Resident G was c bathroom, with h 2/22/11 at 9:15 a walked in there to was observed, ag a.m., with his was bathroom adjusti was in the bathroom. RN #2 indicated, 2/25/11 at 10:30 being reviewed at to be up on his or indicated the resi assistance to get evening before. This federal tag in number IN00086	Guide, the assignment NAs to guide care, was #2 on 2/21/11 at 11:00 Guide indicated Resident stance of one with all g and bathing and subserved to be up in his his walker, by himself, on him. He indicated he had to use the restroom. He gain on 2/23/11 at 9:10 clker, standing in the ling his clothing. No one from with him, or in the lind during interview on a.m., Resident G was legain to see if he was safe with his room. She dent had needed up from his chair the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	DING		COMPL	ETED
	155348	1			02/25/2	011
		B. 1111		ADDRESS, CITY, STATE, ZIP CODE		
ROVIDER OR SUPPLIER			l			
W CARE CENTER			EVANS			
				PROVIDER'S PLAN OF CORRECTION		(X5)
*				CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
review, the facili to a resident who activities of daily dependent reside isolation, in total the resident had be and not been protimely manner, supplied as ordered not assisted by two transfer. Findings include Resident N was controlled and renal failure Clostridium Differ the bowel tract] a care [extensive a supplied as ordered assignment form 2/21/11 at 10:55	ty failed to provide care was unable to carry out viving, for 1 of 1 totally int [N] requiring sample of 17; in that, been incontinent of stool wided perineal care in a upport hose were not id and the resident was wo staff to move and bbserved on 2/21/11 at #1 indicated the resident rom open heart surgery, and was in isolation for ficile [C-Diff infection of and that he required total ssistance]. Guide" [CNA] was provided, on a.m., by LPN #1.	F03	12	inserviced on 2/22/11 by Staff Devlopment Coordinator regarding following the Care Guide as written.2. Interviews were conducted on 2/23/11 by ADON with all interviewable residents being cared for by cr #2 regarding care and treatment performed by any associates. allegations of mistreatment and/or roughness were reporteduring interviews.3. Nursing Department will observe 3 cnaron alternate shifts providing causing checklist, each week to ensure appropriate care is provided per the Care Guide. Observations will be completed times a week. 4. Audits will be completed by Nursing Admin. observation checklist 3 times a week for 3 months, then 2 times week for 3 months, then 2 times week for 6 months. Audits will be reviewed by the PI Committee monthly for 12 months. PI Committee will determine need.	the na nt No ed s are, d 3 e of a es a ly	
Resident IV's inte	iventions included the					
	Based observation review, the facili to a resident who activities of daily dependent reside isolation, in total the resident had and not been protimely manner, s applied as ordere not assisted by two transfer. Findings include Resident N was of 10:15 a.m. LPN was recovering find the resident had renal failure Clostridium Difficulty the bowel tract] a care [extensive a The "Daily Care assignment form 2/21/11 at 10:55	Based observation, interview and record review, the facility failed to provide care to a resident who was unable to carry out activities of daily living, for 1 of 1 totally dependent resident [N] requiring isolation, in total sample of 17; in that, the resident had been incontinent of stool and not been provided perineal care in a timely manner, support hose were not applied as ordered and the resident was not assisted by two staff to move and	Based observation, interview and record review, the facility failed to provide care to a resident who was unable to carry out activities of daily living, for 1 of 1 totally dependent resident [N] requiring isolation, in total sample of 17; in that, the resident had been incontinent of stool and not been provided perineal care in a timely manner, support hose were not applied as ordered and the resident was not assisted by two staff to move and transfer. Findings include: Resident N was observed on 2/21/11 at 10:15 a.m. LPN #1 indicated the resident was recovering from open heart surgery, had renal failure and was in isolation for Clostridium Difficile [C-Diff infection of the bowel tract] and that he required total care [extensive assistance]. The "Daily Care Guide" [CNA assignment form] was provided, on 2/21/11 at 10:55 a.m., by LPN #1.	Based observation, interview and record review, the facility failed to provide care to a resident who was unable to carry out activities of daily living, for 1 of 1 totally dependent resident [N] requiring isolation, in total sample of 17; in that, the resident had been incontinent of stool and not been provided perineal care in a timely manner, support hose were not applied as ordered and the resident was not assisted by two staff to move and transfer. Findings include: Resident N was observed on 2/21/11 at 10:15 a.m. LPN #1 indicated the resident was recovering from open heart surgery, had renal failure and was in isolation of the bowel tract] and that he required total care [extensive assistance]. The "Daily Care Guide" [CNA assignment form] was provided, on 2/21/11 at 10:55 a.m., by LPN #1.	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Based observation, interview and record review, the facility failed to provide care to a resident who was unable to carry out activities of daily living, for 1 of 1 totally dependent resident [N] requiring isolation, in total sample of 17; in that, the resident had been incontinent of stool and not been provided perineal care in a timely manner, support hose were not applied as ordered and the resident was not assisted by two staff to move and transfer. Resident N was observed on 2/21/11 at 10:15 a.m. LPN #1 indicated the resident was recovering from open heart surgery, had renal failure and was in isolation for Clostridium Difficile [C-Diff infection of the bowel tract] and that he required total care [extensive assistance]. The "Daily Care Guide" [CNA assignment form] was provided, on 2/21/11 at 10:55 a.m., by LPN #1.	Based observation, interview and record review, the facility failed to provide care to a resident who was unable to carry out activities of daily living, for 1 of 1 totally dependent resident (had been incontinent of stool and not been provided perineal care in a timely manner, support hose were not applied as ordered and the resident was not assisted by two staff to move and transfer. Findings include: Resident N was observed on 2/21/11 at 10:15 a.m. LPN #1 indicated the resident was recovering from open heart surgery, had renal failure and was in isolation for Clostridium Difficile [C-Diff infection of the bowel tract] and that he required total care (extensive assistance). A BUILDING J WING STREET ADDRESS, CITY, STATE, ZIP CODE 2819 NORTH ST JOSEPH AVENUE EVANSVILLE, IN47720 1. CNA #2 was immediately suspended pending investigation. Nursing staff was inserviced on 2/22/11 by Staff Devlopment Coordinator regarding following the Care Guide as written 2. Interviews were conducted on 2/23/11 by the ADON with all interviewable residents being cared for by cna #2 regarding care and treatment performed by any associates. No allegations of mistreatment and/or roughness were reported during interviews. 3. Nursing Department will boserve 3 cnas on alternate shifts providing care, using checklist, each week to on alternate shifts providing care, using checklist, each week to observation shediled by suspended pending investigation. Nursing staff was inserviced on 2/23/11 by the ADON with all interviewable resident was not assisted by two staff to move and transfer. Findings include: Resident N was observed on 2/21/11 at 0.015 a.m. LPN #1 indicated the resident was recovering from open heart surgery, had renal failure and was in isolation for Clostridium Difficile [C-Diff infection of the bowel tract] and that he required total care (extensive assistance).

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155348			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMPL 02/25/2	ETED
		100070	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	02,20,2	
NAME OF I	PROVIDER OR SUPPLIER			1	ORTH ST JOSEPH AVENUE		
	EW CARE CENTER			EVANS'	VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
ing	following:	ESC IDENTIFIEND IN ORMATION)		1710			DATE
		heart surgery, remind me					
	1	• • •					
	to use a pillow to splint my chest when I cough. I have several incisions on my						
	chest- tell the nurse if they look different						
	or like they are sore. I need assistance						
	with transfers as I am only starting to						
	recuperate from my surgery. [Listed to						
	have 2 + person physical assistance.] I						
	am more confused than when I was						
	admitted."						
	This same information was part of the						
	residents care plan dated 12/15/10.						
	•						
	Resident N was o	observed to receive a late					
	partial bath on 2/	22/11 at 2:45 p.m. CNA					
	#2 was observed	carrying clean linens to					
	the resident's iso	lation room at that time.					
	CNA #2 indicate	d she was going to clean					
	him up for the da	y. At 2:50 p.m., the					
	resident informed	d the CNA he thought his					
	bowels had move	ed. She rang the call light					
	for a stool specin	nen to be obtained. LPN					
	#3 entered the ro	om at 2:55 p.m. At that					
	time, the resident	t was turned over from					
	his back. The res	sident had been					
	incontinent of bo	wel with a dark, drying					
	ring 4-6 inches fi	rom the incontinent stool.					
	Neither the LPN,	, nor the CNA would					
		e resident was last turned					
	and/or reposition	ed.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4MR811 Facility ID:

000239

If continuation sheet

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURV	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155348	B. WING		<u> </u>	02/25/2011	
NAME OF F	PROVIDER OR SUPPLIER	3	STREE	T ADDRESS, CITY, STATE, ZIP	CODE		
			2819 NORTH ST JOSEPH AVENUE				
PARKVIEW CARE CENTER			EVANSVILLE, IN47720				
` ' 		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)	
·		ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	MPLETION DATE	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION) The both was then started. The resident		TAG	BEITEIERCT	DAIL		
	The bath was then started. The resident was observed to be in bed with bilateral						
		e were removed for skin					
		se were then applied to					
" "		rt hose had not been on					
	prior to that time	2.					
	While receiving	a partial bath, the CNA					
	_	a partial bath, the CNA at to turn to the right side;					
		aints of pain in the right					
	1	iving skin care to the					
		omplained of pain and					
	· ·	• •					
		me the area was wiped.					
		ed excoriated and very					
	_	le brief was applied for					
	the resident.						
	Once the bath wa	as completed, the CNA					
		hands/arms to the					
		sident was lying flat on					
		bbed the CNA's hands;					
	· ·	tugged to get the resident					
		ion on the edge of the					
	"	nt would then lean back or					
		ould not hold his balance.					
		ued her care of the					
		The CNA then applied a					
		ident's shoes, and					
	-	esident to the wheel chair.					
		leted the task, emptied the					
	1	the unit etc. Reporting					
	_	e arm, and excoriation					
	1 ^	d prior to her leaving the					
		a prior to nor reaving the					

JOSEPH AVENUE			
STREET ADDRESS, CITY, STATE, ZIP CODE 2819 NORTH ST JOSEPH AVENUE EVANSVILLE, IN47720			
VIDER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE			